



## Was D.D. Palmer that Wrong?

When D.D. Palmer developed the system he termed chiropractic, he reasoned from a sound principle. Yet it was a principle that was substantially rejected by his contemporaries who practiced spinal adjusting; and, though unchanged by time, is mostly rejected today by his successors, particularly in chiropractic procedures applied to the cervical spine.

Palmer called the principle a "basic fact." Referring to the practice of spinal adjusting as an art that had existed for centuries before his time, and stating emphatically that he was not the first to adjust spinal vertebrae, he wrote: "I do claim, however, to be the first to replace displaced vertebrae by using the spinous and transverse processes as levers wherewith to rack subluxated vertebrae to normal position, and from this basic fact, to create a science which is destined to revolutionize the theory and practice of the healing art."(1)

Obviously dissatisfied with the contemporaneous techniques of adjusting subluxated vertebrae, Palmer developed a leverage procedure designed to more effectively correct the vertebral misalignments of a subluxation. A more efficient method of correcting vertebral subluxations, or displacements, was important to Palmer because replacement to normal position was a prerequisite and essential element in determining and creating a tested body of knowledge; in short, a science. He makes this fact clear in his statement quoted above: the replacement of vertebrae to normal position is the basic fact from which he would create his science; an essential fundamental of his methodology. The significance of Palmer's replacement principle is further enhanced by his several references to the adjustment as being a vertebral correction process. "Remember", he states, "adjustments are only made when a vertebra is returned to (its) normal position." (2)

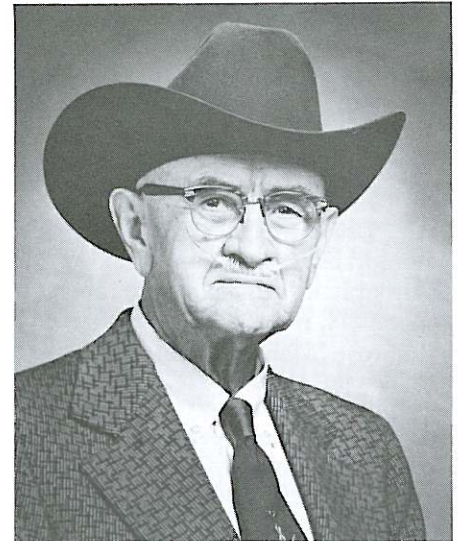
Among Palmer's chiropractic contemporaries was a medical doctor, Alva A. Gregory, a graduate of the University of Texas. Gregory completely rejected Palmer's vertebral replacement principle, and substituted and taught his own theory. Defining a vertebral subluxation (Gregory called it a leison) as "any deviation from the normal approximation of adjacent vertebrae" (3), he viewed the adjustment as a "relaxation of the spinal ligaments." (4) He did state, however, that "adjustment of the spine means, literally, to procure therein a normal condition, and freedom from all interference with the spinal nerve supply which may result from spinal leisons."(5) Therefore, Gregory recognized the meaning of the term adjustment as being "to bring into proper or exact position" (6), but his procedures indicated that he was a manipulator of vertebrae, not necessarily concerned with the replacement or restoration to normal position of displaced vertebrae. If he relaxed the spinal ligaments, and separated the articulations, thereby overcoming the musculature contraction, he appeared satisfied.

Palmer and Gregory were equally strong advocates of spinal adjusting for the alleviation of disease, both acute and chronic. Both men agreed that the vertebral subluxation (or leison) was the basic factor in causing disease. They disagreed however, on the nature of the subluxation. To Palmer, it was a displaced vertebra, impinging on nerve fibers, deranging their function; to Gregory, the vertebral leison was a deviation of adjacent vertebrae from their normal approximation, causing interference with the spinal nerves, and "the cause of derangement of function, existing or manifest, in all forms of disease, both acute and chronic."(7)

The real disagreement between Palmer and Gregory seemed to go to

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## Profiles in Chiropractic



*Editor' Note: The MONOGRAPH presents the third in a series of profiles of NUCCA members who are nationally known for their efforts in advancing their profession. In two previous issues, the MONOGRAPH profiled Dr. Clarence F. Aumann of Indiana and Dr. James R. Coder of Pennsylvania. These two doctors, and the subject of this profile, Dr. Lewis H. McLellan of Arizona, have served humanity through chiropractic for a total of over 150 years, each having practiced over 50 years.*

**Lewis Herbert McLellan**, born September 14, 1892 in the McLellan farmhouse in Baron County, Wisconsin, was the first of 13 children. The eldest of six brothers and six sisters, it is not surprising that he grew up to be a teacher, leader, and fighter - - a formidable opponent of those who would restrict, dilute, or degrade his profession.

Following his early years on the farm, Lewis McLellan worked for the Wisconsin Highway Commission, first as a surveyor and later as an engineer, building bridges and roads. Several of his bridges in the back country are still in use today.

During the 1918 influenza epide-

*Cont. on Page Two . . .*

The Upper Cervical

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*"Profiles in Chiropractic," cont. from front page . . .*

mic. Lewis McLellan first became a chiropractic patient. Having learned chiropractic principles on the many occasions when he took his Uncle Ambrose Mansfield on the 60-mile train trip to see Dr. Williams at Chippewa Falls, Wisconsin, the young engineer realized that these principles made sense. Consequently, he placed himself under chiropractic care wishing to avoid the "flu" which he did. Many of his co-workers and friends were stricken.

In 1921, Lewis McLellan, his wife and 3-year old son, went to Davenport Iowa where Lewis enrolled in the Palmer School of Chiropractic.

After receiving his degree in chiropractic, Dr. McLellan opened an office in Jerome, Arizona, home of the Little Daisy Copper Mine. A typical early mining town, brawls, shootouts, and knifings were so common that Dr. McLellan carried a Colt six-shooter when making house calls. Later, Dr. McLellan moved to the more peaceful community of Mesa. While here he introduced the first neurocalometer to Arizona, helped to form the Arizona State Chiropractic Association, and served as its vice-president and as a director.

Joining the faculty of the Ratledge Chiropractic College in Los Angeles, Dr. McLellan established the College's first X-ray Department. It was at Ratledge College that Dr. McLellan first learned of the Palmer Upper Cervical technique from Dr. B.J. Palmer who lectured at Ratledge about 1932. Dr. McLellan immediately established and directed an upper cervical clinic at the College, and upper cervical has been his speciality ever since.

Returning to private practice in San Jose, California, Dr. McLellan became secretary-treasurer of the Chiropractic League of California, and also served as an assemblyman for the International Chiropractors' Association. He was a charter member of the Palmer Standardized Chiropractic Council, and an expert witness on chiropractic procedures in many "milestone" cases before the California courts, including the famous McGranahan case.

McLellan's favorite state of Arizona, however, beckoned, and he returned to Mesa where he continued to serve as ICA assemblyman. He was appointed to the Arizona State Board of Chiropractic Examiners, serving two terms of three years. He designed and built the McLellan Chiropractic Clinic at 1626 North Country Club Drive.

In 1949, Dr. McLellan attended his first class in the new upper cervical procedure presented by Dr. John F. Grostic in Ann Arbor, Michigan. He continued attending these classes until Dr. Grostic's untimely death in 1964. Since then, Dr. McLellan has affiliated himself with the upper cervical research work of Dr. Ralph R. Gregory, Monroe, Michigan. He is a member of the National Upper Cervical Chiropractic Association, Inc. (NUCCA)

Asked to cite some of his outstanding cases, Dr. McLellan replied: "I could write a book on that subject." The case that first came to his mind was that of a boy whose left leg was paralyzed from an automobile accident. After X-ray examination, an atlas adjustment, and a few hours rest, the boy's paralysis disappeared completely.

Then there was the famous "jack-hammer" case, the construction worker who one day laid down his hammer and wandered off the job. Later found, he was unable to remember or speak a word, and was placed in the state institution. A brother who took him on periodic outings brought him one day to the McLellan Clinic. Dr. McLellan X-rayed and adjusted the former construction worker's atlas. Immediately, he sat up and demanded: "What did you do to me?". The procedure was explained to him. Within two weeks, he was released as cured from the state institution.

One of Dr. McLellan's favorite

patients was Dr. Mabel Palmer, wife of Dr. B.J. Palmer, who spent her final years in Tucson, Arizona. At B.J. Palmer's request, Dr. McLellan rendered chiropractic services to Dr. Mabel, driving each week the 200-mile round trip to Tucson.

Dr. McLellan's success as a dedicated chiropractor has influenced many young people to choose chiropractic as their life's work.

Past 80 years of age, over 50 years in practice, Dr. McLellan still exhibits the fighting spirit that in his younger years took him West, sustained him in the courts of California, fighting for chiropractic, and supported him in his constant search for newer and better techniques with which to successfully resolve his practice problems. Ever young in spirit he has remained; ever faithful he has served, true to the principles of D.D. Palmer, the founder of chiropractic.

Dr. McLellan reminds us of the statement reputed to be the last printed words of Dr. B.J. Palmer: "My illustrious father placed this trust in my keeping, to keep it pure and unsullied or defamed. I pass it on to you unstained, to protect as he would have you do. As he passed on, so will I. We admonish you to keep this principle and practice unadulterated and unmixed."

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# "How to Adjust the Atlas Subluxation Complex"

(Con't from Vol. 1, No. 4)

The Horizontal Resultant (HR) varies in length according to the magnitude of the Height and Rotation vectors. The longer the HR, the more difficult the adjustment may be. For example, the adjustor will find it easier at first to align himself to a H1A2 with its HR of 2.23 inches in comparison to a H9A9 which has a HR of over 12 inches. However, if the adjustor thoroughly comprehends the principles involved, he will handle either subluxation with ease.

A H5A5 subluxation has been the basis of discussing the adjustment principles so far in these articles. It was chosen because the HR of approximately 7 inches is about mid-point between a simple and difficult subluxation listing. Therefore, it will continue to be used in explaining the phases and steps utilized in adjusting anteriors. Confusion could result from using different subluxation listings for different procedures.

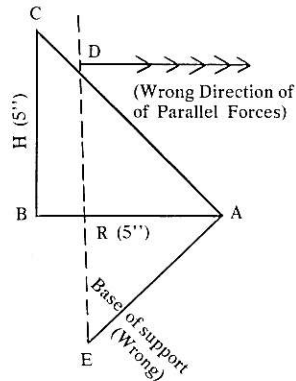
After describing the steps of each phase, and their application, the common errors will be discussed. This should acquaint the adjustor with these errors so he can guard against them.

## APPROACH PHASE: COMMON ERRORS

The most common error observed in the Approach Phase is that of incorrectly positioning the adjustor's feet, or base of support, to the HR. The tendency of many adjustors is to stand directly opposite the patient's transverse process. Such a stance could succeed when the HR is only 2 or 3 inches in length, but it is fatal to the reduction of laterality of atlas, kink, rotation of atlas, laterality of the odontoid process of axis, and/or rotation of the spinous of axis in the subluxation that requires a longer HR. For example, in a subluxation necessitating an HR of 7 inches, a base of support positioned opposite to the patient's transverse process would require excessive rotation of the adjustor's spinal lever in order for him to reach the distal end of the HR. Consequently, his parallel forces and Notch-Transverse Resultant would be so excessively and obliquely position-

ed in relation to the HR that he would, in adjusting the patient, increase practically all of the misalignment factors of the subluxation he was attempting to reduce.

This error is illustrated in the following schema. Note the angle of the parallel forces in relation to the HR. Compare with the schema in Vol. 1, No. 4 MONOGRAPH. (Same Scale)



In the schema in Vol. 1, No. 4, it was explained that point D is the point from which the adjustor establishes his base of support. If he establishes his stance from point A, the patient's transverse process, he must rotate his body to get his position over point C. Point C is where he must be at the moment he delivers his adjustment; any point on the HR that is between points C and A, and to the extent it is toward A, will lessen the adjustor's effectiveness in reducing the misalignments of the subluxation. The requirement of excessive rotation of the adjustor's spinal lever in order to get over point C will cause his parallel levers to diverge from an approximate parallelism to the HR toward an oblique position to the HR. The greater the degree of oblique angulation, the greater the error. Thus, if he picks his base of support from point A, he must rotate his spinal lever around point E to get over point D with his episternal notch, and his parallel forces will be manifested in the adjustment at right angles to his spinal column along the lines indicated in the schema.

The second most common error in the Approach Phase is the improper positioning of the adjustor's feet to the HR. The inside foot must be first placed obliquely to the HR, and then pivoted from the heel until it is at an exact 90 degree angle to the HR.

These two elements - - position and pivot - - are essential because the proper positioning of the inside foot determines the plane through which the adjustor's spinal lever will travel when he settles back. The pivoting of the foot from the heel assists in setting up the plantar reflex. (q.v.)

Positioning the inside foot at right angles to the HR assists the adjustor in settling back at right angles to the HR. Correctly done, the plane of the adjustor's shoulders and pelvis are approximately in line with the HR at this point in the procedure. That is to say that a line drawn through the adjustor's shoulders from the center of one glenoid fossa to the center of the other glenoid fossa, and a line drawn through the centers of acetabulum, are comparatively parallel to the HR. These lines represent respectively the shoulder and pelvic levers, and will be referred to as the shoulder and pelvic levers hereafter.

Pivoting the foot from its oblique angle to that of a 90 degree angle in relation to the HR is always accomplished from the heel. The heel is the center of motion for the pivoting act. During the pivoting action, the plantar surface of the foot is in contact with its supporting surface. Note that this is a pivoting action, not just a turning of the foot from any center of motion.

In pivoting the outside foot to an approximate 40 degree angle to the HR, the objectives sought are two in number: (1) To complete the setting up of the plantar reflex, and (2) to establish the outside foot at an angle that serves as a bridge in the Pelvic Lever Phase.

The importance of the plantar reflex in the adjustment has been fully discussed in Vol. 1, No. 4. The "bridging" action of the outside foot will be considered in the Pelvic Lever Phase.

A third error seen in the Approach Phase is the omission of the Neck-Lock action. This device has been fully treated in Vol. 1, No. 4. It should be noted, however, that in adjusting long resultants, the neglect of the Neck-Lock action may result in causing whiplash injury to the adjustor.

Another serious error seen in the Approach Phase is that of turning the pelvic lever forward when advancing the outside foot. This error arises

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## NUCCA Membership

Numerous inquiries have been received regarding membership in the National Upper Cervical Chiropractic Association, Inc. (NUCCA). There is some confusion as to the existence of two organizations. Frequently asked is the question regarding the benefits of membership. The following information is pertinent:

NUCCA is a national fraternal organization; it is non-profit. Any chiropractic graduate from a chartered college of chiropractic in good standing in his state of residence may be eligible for membership, regardless of his methods of practice. Initial membership applications shall be accompanied by a fee of \$75.00. Annual dues thereafter are \$50.00, due and payable on the 15th of each April. Membership applications are obtainable from the MONOGRAPH Editor.

Chiropractic students, who are actively enrolled in a chiropractic college, are eligible for NUCCA membership. Initial applications from students shall be accompanied by a fee of \$12.00. Annual dues thereafter are \$10.00, due and payable on April 15th of each year. Student membership applications are also obtainable from the MONOGRAPH Editor.

NUCCA membership services include the publication of technical tracts, chiropractic literature, seminars, conventions, information re NUCCRA research, assistance with problem cases, information on x-ray problems, adjusting problems, etc. NUCCA also publishes the MONOGRAPH which circulates throughout the United States, and is sent to Canada, England, France, Belgium, Spain, Australia, New Zealand, South Africa, and South America. The MONOGRAPH is also sent to several Chiropractic Colleges. NUCCA's educational programs and seminars are predicated upon upper cervical techniques and the effects of upper cervical subluxations on the spinal column and the neuro-muscular system.

The National Upper Cervical Chiropractic RESEARCH Association, Inc. (NUCCRA) was incorporated as a non-profit organization on the 6th day of October, 1971 under the appropriate Michigan Statutes. A separate

corporation was needed because NUCCA could not conduct research activities under its status. Research projects conducted by NUCCRA are for the purpose of scientifically investigating chiropractic procedures and practices. The results of these investigations are available to NUCCA members. The NUCCRA Research Director is Professor Daniel C. Seemann, University of Toledo. NUCCRA has no membership other than the members of its Directive Board.

NUCCRA research is supported by NUCCA membership dues, and by donations from chiropractors and the public. Listed as a scientific organization, NUCCRA may accept donations, legacies, transfers, or gifts which are deductible for Federal Estate and Gift Tax purposes. Contributors may deduct donations to NUCCRA research from their Federal Income Taxes as provided in Section 170 of the Code.

Further benefits accruing to members of NUCCA, the public, profession, and individual practitioners arising from NUCCRA research activities are found in the purposes of the corporation. Too numerous to list here, they are available in a NUCCRA pamphlet which may be obtained by writing the NUCCA  
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## NUCCA Scholarship Awards

It was announced at the May NUCCA Convention that the NUCCA Directive Board has authorized a scholarship grant-in-aid award of \$200.00. This sum will be paid to chiropractic students currently enrolled in a chartered college of chiropractic who submit to the MONOGRAPH editor an acceptable article pertaining to the upper cervical spine. The announcement was made by Professor Daniel C. Seemann, NUCCRA Research Advisor.

Submitted articles may deal with any aspect of the Occipital-atlanto-axial area of the cervical spine: mechanics, neurological manifestations, analyses of cervical subluxations, corrective techniques for cervical subluxations, detrimental effects of upper cervical subluxations on the human organism, etc.

All entries will be judged by the NUCCADirective Board and by Professor Seemann. Their judgment

*"How to Adjust the Atlas Subluxation Complex" cont. from page 3.*

when the adjustor does not confine the advancing action to the center of motion in his acetabulum on the side of the outside foot, and does not consciously lock his pelvis to prevent it from going forward. This locking action occurs just anterior to the anterior spine of the pelvis. At the moment of the advancement of the adjustor's outside foot, his weight is temporarily shifted to his inside foot and his pelvis is acting momentarily as a cantilever. Thus there is a tendency for the pelvic lever to rotate forward on the side opposite to the weight supporting leg. This error is particularly noticable in subluxations requiring a long HR, which, in turn, necessitates a longer A-P spread of the adjustor's feet, a longer A-P base of support, in order to obtain greater angulation of the pelvic and shoulder levers. To correct this error, the adjustor must consciously advance his outside foot the required distance, concentrate on centering the advancing movement to the acetabulum on that side, and keep the center of motion confined to the acetabulum. This will cause greater dropping of the pelvic lever on the side of the outside foot which is

*Cont. on Page 5 . . .*

will be final. Accepted articles become the property of the National Upper Cervical Chiropractic Association, Inc. Winners will be announced at the 1975 NUCCA Convention.

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# The Case of Dorothy Fischer

*Editor's Note: This case dramatically illustrates the effects of the adjustic correction of the misalignments of the occipital-atlanto-axial subluxation on the pelvis and lower spinal vertebrae. It also poses a question: If a slight misalignment [subluxation] of a vertebral segment can cause neurological interference subjacent to the second cervical, why doesn't the far greater displacement of a dislocation cause greater interference requiring its correction before there is an alleviation of the patient's health problem?*



*Mrs. Fischer was adjusted once on the axis vertebra by Dr. B.J. Palmer. Since that time she has been adjusted several times on the atlas vertebra over a period of several years. She has never been adjusted below axis. For the past 30 years, she has been checked regularly, adjusted when necessary. At no time has any neurological interference been detected at the site of the dislocation.*

*The lateral cervical film, showing the dislocation between C5 and C6, is the original film, taken in 1943. Subsequent films show no considerable changes in the luxation site.*

Mrs. Fischer tells her story in her own words:

"On March 31, 1940 I was in an auto accident. Following the accident, I was unconscious for five weeks. My skull was fractured, both femurs broken, and I had a severe concussion.

"Holes were drilled in the femurs above both knees into which pins

were inserted and weights applied. I was placed in a body cast. My femurs were not set until seven weeks after the accident. Both legs had open reduction, and osteomyelitis was found in the right leg. A silver band was applied to the left leg. Two more operations were performed for the removal of bone splinters during my stay in this hospital.

"The body cast was removed one week before I was discharged on June 28, 1941. I was still confined to a bed or wheelchair.

"In October of 1941, I was admitted to the University of Michigan Hospital. Here I underwent surgery again on the right leg for the removal of a loose piece of bone. Shortly after surgery, I was taught to walk again with the aid of crutches.

"My right leg continued to drain, sometimes forming pockets which had to be probed. Orthopedic shoes were prescribed, and the right shoe was built up one-and-one-half inches to make up for the deficiency in its length.

"About this time a friend suggested that I consult Dr. R.R. Gregory, a chiropractor in Monroe, Michigan. Dr. Gregory arranged for cervical spinal x-rays, and it was at this time that the dislocation between my fifth and sixth cervical vertebrae was first discovered. Dr. Gregory recommended that I go to the Palmer Chiropractic Clinic in Davenport, Iowa and consult Dr. B.J. Palmer as Dr. Gregory was hesitant to adjust me because of the severity of the dislocation.

"I went to the Palmer Clinic where Dr. B.J. Palmer, after examination, adjusted me. Following the one adjustment he gave me on my neck, I immediately felt a warming sensation in my right thigh. Within three days the draining stopped for the first time since the accident. I then returned to Monroe, after a three weeks stay at the Clinic, and continued under Dr. Gregory's care.

"Gradually I became able to walk with only a cane for support, and eventually without any assistance at all. My right leg continued to lengthen until the built-up shoe has been decreased to normal. I have not had a recurrence of the osteomyelitis and, of course, no pockets of infection

and no drainage, except after one occasion when I fell and struck my right thigh against a low cupboard door. The fall knocked me out of adjustment, but immediately after being adjusted again by Dr. Gregory, the infection cleared up and the drainage ceased. I felt the same warm sensation throughout my right thigh after Dr. Gregory's adjustment as I did after Dr. Palmer's.

"My present condition is that I am able to walk normally and without assistance from any aid whatsoever. I do my own housework and drive a car. I live a fairly normal life. I do, however, have some difficulty in bending my knees. I keep myself chiropractically checked on a monthly basis."

*"How to Adjust the Atlas Subluxation Complex." cont. from page 4.* desirable as it creates faster and greater conversion of the pelvic and shoulder levers to a more vertical plane.

However, when the adjustor's outside foot is sufficiently advanced, and the pelvic lever dropped, he may fall into a weight distribution error. At this point the greater body weight will be supported by the inside leg. Unless he carefully re-distributes his weight so that it is equally supported by both legs, or there is slightly more on the outside leg, his inside leg will act as a fulcrum. This will twist his pelvis in the horizontal plane during the Settleback phase. The correction factor is to bring a greater portion of his body weight over the outside leg without substantially changing his pelvic lever in its parallel relation to the H.R.

An aid in mastering the act of advancing the outside foot is to compare it with the act of walking. In walking there is a constant shifting of the base of support as one foot is advanced in front of the other. There is, however, no substantial turning of the pelvis in the horizontal plane. If one keeps the knees "loose" while walking, it helps to set the insertions of the hamstring muscles which, in turn, assist in maintaining the pelvis as a first class lever. Keeping the knee loose when advancing the outside foot also assists in maintaining the adjustor's pelvis as a first class lever, an important step in stabilizing the parallel forces in the desired position in relation to the HR.

*To be Continued Next Issue . . .*

*"Was D.D. Palmer that Wrong," cont. from front page . . .*

the question of whether subluxated vertebrae displace or approximate; whether they go out of normal position or whether they draw together. Gregory was so convinced that vertebrae could not "slip" out of place that he stated: "The idea of a vertebra slipping out of place will never appeal to thinking and intelligent people." (8)

Today it is simply a matter of fact, supported by x-ray analysis, that cervical vertebrae, at least, can slip out of place, separate at their articulations, and approximate. In the occipital-atlanto-axial area of the cervical spine, abnormal movement of the atlas, axis, and occiput is measurable into all three bodily planes of motion. Thus modern chiropractic validates Palmer's vertebral replacement principle.

But the problem of the adjustment still remains. Many of today's chiropractors may never have heard of Gregory's approximation theory; but they have been taught, and they daily practice, the mechanically inept adjusting techniques which he taught and promoted in 1912, techniques which are designed only to open the articulations and relax the spinal ligaments. This is manipulation, not adjustment. Neither is it the specific technique advocated by D.D. Palmer, the replacing of displaced vertebrae. Such is not Palmer's chiropractic. As an example of how far the profession has moved from Palmer's replacement principle - - - from Palmer's chiropractic - - - one needs only to read the medicare regulations in which manipulation is equated with chiropractic practice.

Even as Palmer recognized the importance of specifically restoring the displacements of a subluxated vertebral segment to its normal position, he realized the dangers of maladjustment. "Any person," he said, "can learn to hit the high places replace and displace vertebrae, - relieve one disease and cause others." (9) Palmer did not condone the mechanically inept methods of adjusting upper cervical vertebrae utilized by Gregory, and others, nor would he have approved those same inept methods still being taught and practiced today in which disproportionate leverage is used incorporating lack of control of direction

and force. That such techniques open the articulations and temporarily relax spinal ligaments is not disputed; that they consistently and accurately replace upper cervical vertebral subluxations to normal position is disputed. Their rotary character, coupled with lack of control of either force or direction of force, imparts to them a dangerous characteristic.

#### NUCCA RESOLUTION

The National Upper Cervical Chiropractic Association, Inc. (NUCCA), greatly concerned about many of the upper cervical adjusting techniques being taught and practiced today adopted on September 21, 1973, a resolution which called on the chiropractic colleges and national chiropractic organizations of the United States and Canada "to actively promote the scientific investigation of all chiropractic procedures and practices relating to the vertebral subluxation to the end that the use of any and all such procedures and practices that fail to reduce or can increase the misalignment factors of a vertebral subluxation be considered unethical."

The International Chiropractors Association, the American Chiropractic Association, the Canadian Chiropractic Association, and all chiropractic colleges within the United States and Canada were respectfully and specifically requested to adopt and activate the NUCCA Resolution for the general good, protection of, and welfare of the public and the chiropractic profession.

This resolution, accompanied by a letter, was released to the colleges and national organizations in the Fall of 1973. To date, nearly one year later, not one of the national organizations has replied. Four of the twelve colleges have replied. One college agreed with the NUCCA objectives, one agreed with the resolution but did not adopt it, one asked for more data (which was sent), and the fourth gave wholehearted support but failed to adopt the resolution.

Perhaps the feeling exists that NUCCA is attempting to force its techniques upon the profession. Nothing could be further from the truth. NUCCA is simply concerned over upper cervical techniques that are highly questionable, and may not

be in the public interest. Further, NUCCA is concerned with the increasing disregard for Palmer's vertebral correction principle; in short, for Palmer's chiropractic.

#### REFERENCES:

- (1) Palmer, D.D.: the Science, Art, and Philosophy of Chiropractic (1910). Portland Printing House Company. Page 11.
- (2) Ibid, Page 42.
- (3) Gregory, Alva A.: Spinal Treatment, Science, and Technique (1912). Palmer-Gregory College. Page 129.
- (4) Ibid. Page 437.
- (5) Ibid. Page 437.
- (6) Webster's New International Dictionary, Second Edition
- (7) Gregory, A.A.: Spinal Treatment, Science, and Technique. Page 158.
- (8) Ibid. Page 438.
- (9) Palmer, D.D.: Science, Art, and Philosophy of Chiropractic. Page 51.

*"Nucca Membership," cont. from page 4 . . .*

MONOGRAPH Editor.

NUCCA is interested in developing practitioners who are potential instructors in its techniques and procedures, because of the great need for doctors who can practice and teach efficiently the correction of upper cervical subluxations, and who are trained to apply the techniques evolving from the NUCCA research projects.

The message of NUCCA is one of professional unity based upon demonstrable knowledge of the subluxation through measurement of the manifested physical phenomena of the human organism; in short, a bona fide research program. NUCCA is not in competition with any chiropractic organization, nor is NUCCA. Both are fulfilling a need not previously satisfied. Membership is reserved for those chiropractors and students whose vision and experience encompass the subluxation, wherever it may be proved to exist, as a disease-producing factor in the tradition of Daniel David Palmer, the founder of chiropractic; and who subscribe to the Palmerian principle that the displacements of the vertebral subluxation must be reduced by the adjustment to or toward their normal position as a basic prerequisite to research.

To those who so believe, NUCCA extends a hearty welcome to join with this growing organization.